DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING **01 - MAIN BUILDING** B. WING _____	R **07/12/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE CENTER FOR REHABILITATION AND HEALING	**306 W DUE WEST AVENUE** **MADISON, TN 37115**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Life Safety revisit survey was conducted on 07/12/2019 for all previous deficiencies cited on 06/28/2019. All deficiencies have been corrected, and no new non compliance was found. The facility is in compliance with all regulations surveyed.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

45th day 6-15-19 / 70th day 7-10-19

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #1 Recite LSC	445516	A. BUILDING 01 - MAIN BUILDING B. WING	R 06/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE CENTER FOR REHABILITATION AND HEALING	306 W DUE WEST AVENUE MADISON, TN 37115

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{K 000}	INITIAL COMMENTS Stories: 1 Construction Type: NFPA, II (000); IBC, II unprotected Some plans available on site Constructed: 1968 Sprinklered: Yes Census: 130 A Life Safety Code Follow up Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities on 06/28/2019. During this Life Safety Follow up Survey, Creekside Center for Rehabilitation and Healing was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by:	{K 000}	K 321 A new door was installed on the basement accounting storage room to ensure latching on 7/3/19. A 100% inspection of all other facility doors was conducted on 6/28/19 to ensure all were in compliance with the requirements of K 321. The Director of Maintenance was in-serviced on 7/3/19 as to the requirements listed on the 2567 it relates to the condition of doors throughout the center. A 100% audit of all doors will be completed monthly For the next (3) months to ensure continued compliance with K 321 and the results will be reported in the monthly QAPI meeting June – August 2019 or until substantial compliance maintained.	7/3/19
{K 321} SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied	{K 321}	The results of the audits will be presented by the Director of Maintenance in the monthly Quality Assurance meeting to assure compliance with the requirements of K 321. June – August 2019 or until substantial compliance is maintained.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: NHA | (X6) DATE: 7/3/19

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	445516	A. BUILDING 01 - MAIN BUILDING B. WING _____	R 06/28/2019

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CREEKSIDE CENTER FOR REHABILITATION AND HEALING	306 W DUE WEST AVENUE MADISON, TN 37115

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{K 321}	Continued From page 1 protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the hazardous areas. The findings included: Observation on 06/28/2019 at 8:39 AM, revealed the door to the basement accounting storage room did not self-close and latch within the frame. NFPA 101, 19.3.2.1.3 (2012 Edition) The Maintenance Director was present when this deficiency was identified and the Administrator acknowledged this deficiency during the exit conference (via phone call) on 06/28/2019.	{K 321}	The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director.	
{K 541} SS=D	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry	{K 541}		

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{K 541}	Continued From page 2 Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the laundry chute. The findings included: Observation on 6/28/2019 at 8:44 AM, revealed the holes in the laundry chute door had been covered with a piece of sheetmetal and the latch installed on the laundry chute door did not allow the door to self-close and latch within the frame. NFPA 101, 19.5.4.1 (2012 Edition) NFPA 101, 9.5.2 (2012 Edition) NFPA 82, 5.2.3.3.1.1 (2009 Edition) NFPA 82, 10.2.2 (2009 Edition)	{K 541}	K 541 The single laundry chute has been placed Out of Service effective 7/2/19 and clearly marked. The laundry chute is additionally behind a locked door with an additional sign indicating Out of Service. The Director of Maintenance was in-serviced by the Administrator on 7/2/19 per the requirements listed on the 2567. The laundry chute door will be placed on a daily check to ensure it is not being used to ensure compliance with K 541 for two weeks then weekly thereafter until substantial compliance is achieved. The results of the audit will Be reported in the monthly QA Meeting for a period of (3) months June – August 2019. Or until substantial compliance is achieved. The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director.	7/3/19

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{K 541}	Continued From page 3 The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference (via phone call) on 06/28/2019.	{K 541}	K 761 The Maintenance Assistant completed the annual inspection and testing of the fire doors from 7/1/19 - 7/3/19. All results were reviewed by the Director of Maintenance on 7/3/19.	
{K 761} SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to ensure fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. The findings included: Document review on 06/28/2019 at 8:16 AM, the facility did not provide (correct) documentation of an annual inspection and testing of the fire door assemblies during 2018. NFPA 101, 19.7.6 (2012 Edition) NFPA 101, 4.6.12 (2012 Edition) NFPA	{K 761}	The annual fire door inspection will be placed on the TELS automated system for tracking to ensure test are performed annually in the future. The Administrator in-serviced the Director of Maintenance on the door auditing requirements on 7/3/19 per the requirements of the 2567. The Director of Maintenance will complete a routine audit monthly of all fire doors for a period of (3) months to ensure compliance with K 761 June – August or until substantial compliance is achieved. The results of the monthly audits will be presented by the Director of Maintenance in the monthly Quality Assurance meeting to assure compliance with the requirements of K 761. June – August 2019 or until substantial compliance is maintained. The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director.	7/3/19

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{K 761}	Continued From page 4 101, 4.6.12.4 (2012 Edition) NFPA 101, 8.3.3.1 (2012 Edition) NFPA 80, 5.2.3 (2010 Edition) NFPA 80, 5.2.1 (2010 Edition) NFPA 80, 5.2.4 (2010 Edition) The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference (via phone) on 06/28/2019.	{K 761}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th day 6-15-19 / 70th 7-10-19

PRINTED: 05/02/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #1	445516	A. BUILDING 01 - MAIN BUILDING B. WING _____	05/01/2019

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CREEKSIDE CENTER FOR REHABILITATION AND HEALING	306 W DUE WEST AVENUE MADISON, TN 37115

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K 000	INITIAL COMMENTS Stories: 1 Construction Type: NFPA, II (000); IBC, II unprotected Some plans available on site Constructed: 1968 Sprinklered: Yes Census: 130 A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities on 04/29/2019 and 04/30/2019. During this Life Safety Survey, Creekside Center for Rehabilitation and Healing was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by:	K 000	K 321 New doors ordered for the basement general storage room and the basement accounting storage rooms on 5/14/19. A 100% inspection of all other facility doors was Conducted on 5/13/14 to ensure all Were in compliance with the requirements of K 321. The Director of Maintenance was in-serviced on 5/8/19 as to the requirements listed on the 2567 it relates to the condition of doors throughout the center. A 100% audit of all doors will be completed monthly For the next (3) months to ensure continued Compliance with K 321 and the results will be Reported In the monthly QAPI meeting May – July 2019.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied	K 321	The results of the monthly audits will be presented in the monthly Quality Assurance meeting to assure compliance with the requirements of K 321. May – July 2019. The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director.	6/15/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 5/17/19

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RECEIVED MAY 17 2019

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	445516	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**05/01/2019**

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CREEKSIDE CENTER FOR REHABILITATION AND HEALING	**306 W DUE WEST AVENUE MADISON, TN 37115**

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K 321	Continued From page 1 protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the hazardous areas. The findings included: 1. Observation on 04/30/2019 at 11:57 AM, revealed the door to the basement general storage room did not self-close within the frame and the door was spliting at the sides. NFPA 101, 19.3.2.1.3 (2012 Edition) 2. Observation on 04/30/2019 at 12:11 AM, revealed the door to the basement accounting storage room did not self-close within the frame. NFPA 101, 19.3.2.1.3 (2012 Edition) The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies	K 321		

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K 321	Continued From page 2 during the exit conference on 04/30/2019.	K 321	K 324 The Dietary Director in-serviced the new staff Member #1 on 4/30/19 and again on 5/9/19 who was new and in orientation on to ensure compliance with K324.	6/15/19
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101	K 324	The Dietary Director in-serviced 100% of the remaining dietary staff on 5/9/19 to additionally ensure all staff were aware of how to activate the hood suppression system and the use of a fire extinguisher as a secondary means.	
	Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2		The Staff Development Director added Specific fire suppression Information in the dietary new hire orientation packet on 5/9/19. The Director of Dietary will audit all new employees monthly for (3) months to ensure new staff are education prior to working in the dietary department. The results of the monthly audits will be presented in the monthly Quality Assurance meeting to assure compliance with the requirements of K 324. May – July 2019. The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director.	
	This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to protect the cooking facilities. The findings included: Interview on 04/30/2019 at 11:40 PM, revealed			

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K 324	Continued From page 3 kitchen staff member #1 did not know the know the proper fire control procedures including; the manual activation of the hood suppression system, and the activation of the hood suppression system as the primary means of fire suppression and the use of a fire extinguisher as a secondary means. NFPA 101, 19.3.2.5.1 (2012 Edition) NFPA 96, 10.2.1 (2011 Edition) NFPA 96, 10.5.7 (2011 Edition) Maintenance staff was present when these deficiencies were identified and the administrator acknowledged these deficiencies during the exit conference on 04/30/2019.	K 324	K 353 The wiring attached to the sprinkler pipe in the front entrance will be within compliance on or before 6/15/19. An inspection of all other sprinkler piping was completed on 5/12/19 to ensure no other wires were attached to sprinkler piping. The Director of Maintenance was In-serviced by the Administrator on 5/8/19 on the requirements listed on the 2567.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353	The Director of Maintenance will audit the sprinkler pipes monthly for (3) months to additionally ensure compliance to K 353. The results of the monthly audits will be presented In the monthly Quality Assurance meeting to assure compliance with the requirements of K 353. May – July 2019. The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director.	6/15/19

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K 353	Continued From page 4 Based on observations, the facility failed to maintain the sprinkler system. The findings included: Observation on 04/29/2019 at 10:13 PM, revealed a bundle of communication wires attached to and supported by a sprinkler pipe in the front entrance lobby. NFPA 101, 19.3.5.1 (2012 Edition) NFPA 101, 9.7.5 (2012 Edition) NFPA 25, 5.2.2.2 (2011 Edition) The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 04/30/2019.	K 353	K 521 A contracted vendor is scheduled to complete The required fire damper Inspection on 5/22/19. The fire damper inspection will cover 100% of all fire damper system requirements to ensure inspection compliance with K521 on 5/22/19. The Director of Maintenance was in-serviced by the Administrator on 5/8/19 on the requirements listed on the 2567. The Director of Maintenance will report the status of the inspection to the Administrator upon completion. The results of the damper Inspection will be presented In the monthly Quality Assurance meeting to assure compliance with the requirements of K 541. May and/or July. The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director.	
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to maintain the HVAC systems. The findings included: Document review on 04/29/2019 at 10:45 AM, revealed the facility failed to conduct a 4 year fire	K 521		5/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**05/01/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE CENTER FOR REHABILITATION AND HEALING	**306 W DUE WEST AVENUE MADISON, TN 37115**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 5 damper inspection. NFPA 101, 19.5.2.1 (2012 Edition) NFPA 101, 9.2.1 (2012 Edition) NFPA 90A, 5.4.7.1 (2012 Edition) NFPA 80, 19.4 (2010 Edition) The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 04/30/2019.	K 521	K 541 The laundry chute door was removed and will be repaired to remove the holes, ensure latch mechanism is installed, and hinges are in proper working order on or before 6/15/19.	
K 541 SS=D	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by:	K 541	The center layout was reviewed and no additional laundry chutes are present in the center on 5/1/19. The Director of Maintenance was In-serviced by the Administrator on 5/8/19 per the requirements listed on the 2567. The laundry chute door will be placed on the TELS system to check weekly to ensure compliance with K 541. The results of the weekly audit will Be reported in the monthly QA Meeting for a period of (3) months May – July 2019. The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director.	6/15/19

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	445516	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**05/01/2019**

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K 541	Continued From page 6 Based on observations, the facility failed to maintain the laundry chute. The findings included: Observation on 04/30/2019 at 11:16 AM, revealed the door to the laundry chute was damaged with holes and did not latch. NFPA 101, 19.5.4.1 (2012 Edition) NFPA 101, 9.5.2 (2012 Edition) NFPA 101, 5.2.3.3.1.1 (2009 Edition) The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 04/30/2019.	K 541	K 761 The Maintenance Director completed the annual inspection and testing of the fire doors on 5/13/19. The Maintenance Director completed a 100% inspection of all fire doors in the center on 5/13/19 to ensure compliance with K 761. The annual fire door inspection will be placed on the TELS automated system for tracking to ensure test are performed annually in the future. The Administrator in-serviced the Director of Maintenance on the door auditing requirements on 5/8/19 per the requirements of the 2567.	
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to ensure fire doors assemblies are inspected and tested annually in accordance with NFPA 80,	K 761	The Director of Maintenance will complete a routine audit monthly of all fire doors for a period of (3) months to ensure compliance with K 761. The results of the monthly audits will be presented in the monthly Quality Assurance meeting to assure compliance with the requirements of K 761. May – July 2019. The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director.	5/13/19

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	445516	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**05/01/2019**

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K 761	Continued From page 7 Standard for Fire Doors and Other Opening Protectives. The findings included: Document review on 04/29/2019 at 10:50 AM, the facility did not provide documentation of an annual inspection and testing of the fire door assemblies during 2018. NFPA 101, 19.7.6 (2012 Edition) NFPA 101, 4.6.12 (2012 Edition) NFPA 101, 4.6.12.4 (2012 Edition) NFPA 101, 8.3.3.1 (2012 Edition) NFPA 80, 5.2.3 (2010 Edition) The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 04/29/2019.	K 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	R 06/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE CENTER FOR REHABILITATION AND HEALING	306 W DUE WEST AVENUE MADISON, TN 37115

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{E 000}	Initial Comments A Emergency Preparedness Follow up Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 06/28/2019. During this Emergency Preparedness Survey, Creekside Center for Rehabilitation and Healing was found in substantial compliance with the requirements for participation in Emergency Preparedness Regulations for Long-Term Care Facilities, Federal CFR §483.73. *All deficiencies previously cited on 4/30/2019 are clear and no new deficiencies were cited on Emergency Preparedness.	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 7/3/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	05/01/2019

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E 000	Initial Comments A Emergency Preparedness Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 04/30/2019. During this Emergency Preparedness Survey, Creekside Center for Rehabilitation and Healing was not found in substantial compliance with the requirements for participation in Emergency Preparedness Regulations for Long-Term Care Facilities, Federal CFR §483.73. The requirement at 42 CFR, §483.73 are NOT MET as evidenced by:	E 000		
E 006 SS=D	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.	E 006	E 006 Elopement was added to the Vulnerability Risk Assessment on 4/30/19. All other risk assessment items were reviewed on 4/30/19 to ensure all risk factors were included on the Vulnerability Risk Assessment. The Vulnerability Risk Assessment will be updated on or before November 30, 2019 and will include any updates that are needed. The Vulnerability Risk Assessment will be reviewed by the interdisciplinary team at the next QA meeting in May 2019. The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director.	4/30/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE NHA | (X6) DATE 5/17/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445516	A. BUILDING _____ B. WING _____	05/01/2019

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E 006	Continued From page 1 (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on interviews, the facility failed to complete the risk assessment utilizing an all-hazards approach per the requirements of Federal CFR §483.73. The finding included: Interview on 04/30/2019 at 1:30 PM, revealed the facility's facility based/community based risk assessment for the emergency preparedness program did not utilize an all-hazards approach including the assessment of missing residents. This finding was verified by the administrator during the interview of the facility's emergency preparedness program.	E 006	E 015 The Emergency Disaster Manual total number was updated to include staff, volunteers, and residents for food, water, medical and pharmaceutical supplies on 4/30/19. The Emergency Disaster Manual Alternate sources of energy was updated to reflect the current emergency power source, lighting, fire detection, extinguishing, and alarm systems in place. The Quantity of Provisions and all emergency support equipment will be updated on or before November 30, 2019 and will include any updates that are needed. The assessment of numbers, food, water supplies, and pharmaceuticals along with the emergency support equipment will be reviewed by the interdisciplinary team for the next three months at the Quality Assurance meeting May – July 2019.	4/30/19
E 015 SS=E	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be	E 015	The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director.	

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E 015	Continued From page 2 reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm	E 015		

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E 015	Continued From page 3 systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on document review and interviews, the facility failed to include all policies and procedures for the subsistence needs of residents and staff in the emergency preparedness program. The findings included: 1. Document review and interviews on 04/30/2019 at 1:40 PM, revealed the facility failed to in the policies and procedures address the quantity of provisions of subsistence needs for staff and patients whether they evacuate or shelter in place, include Food, water, medical and pharmaceutical supplies 2. Document review and interviews on 04/30/2019 at 1:40 PM, revealed the policies and procedures for Alternate sources of energy to Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, Emergency lighting, Fire detection, extinguishing, and alarm systems were not accurate of the emergency power available at the building. This finding was verified by the administrator during the interview of the facility's emergency preparedness program.	E 015		
E 030 SS=D	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws	E 030		4/30/19

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E 030	Continued From page 4 and must be reviewed and updated at least annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees.	E 030	E 030 The Emergency Disaster Manual was Updated on 4/30/19 to include The updated contact numbers for all staff, entities providing services Under arrangement, physician Contact, other facilities, and Volunteers. The Emergency Disaster Manual will contact information will be updated as needed bases and at least annually based on terminations, hiring, and/or contracting of new services. The Director of Human Resources will review the contact list and report findings to the interdisciplinary team for the next three months at the Quality Assurance meeting May – July 2019. The Quality Assurance Performance Improvement Committee will include, but not be limited to, the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director.	

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E 030	Continued From page 5 (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to develop a communication plan that includes contact information. The findings included: Document review on 04/30/2019 at 1:45 PM, revealed the facility did not have contact information for all facility staff. This finding was verified by the administrator during the interview of the facility's emergency preparedness program.	E 030		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 031 E 031 SS=D	Continued From page 6 Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to include policies and procedures for primary and alternate means for communicating with facility staff, Federal, State, tribal, regional, and local emergency management agencies in the emergency preparedness program per the	E 031 E 031	E 031 The contact information for FEMA and TEMA were added to the Emergency Disaster Manual on 4/30/19. A review of the Emergency Disaster plan was revlewed by the Administrator on 4/30/19 to ensure no additional contact number was missing. A full review of the contact information Will be performed by the Administrator And findings presented to the interdisciplinary team for the next three months at the Quality Assurance meeting May – July 2019. The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director.	4/30/19

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE CENTER FOR REHABILITATION AND HEALING	306 W DUE WEST AVENUE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 031	Continued From page 7 requirements of Federal CFR §483.73. The finding included: Interview on 04/30/2019 at 1:50 PM, revealed the facility had no record of polices and procedures for primary and alternate means for communicating with facility staff, Federal, State emergency management agencies during an emergency. This finding was verified by the administrator during the review of the facility's emergency preparedness program	E 031		